

VAN DE WARKER (Ely)

THE TREATMENT

OF

ANTEFLEXIONS OF THE UTERUS.

BY

ELY VAN DE WARKER, M.D.,
SYRACUSE, N. Y.

[REPRINTED FROM THE NEW YORK MEDICAL JOURNAL, JUNE, 1876.]



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BY
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THE TREATMENT OF ANTEFLEXIONS OF THE UTERUS.

IN medicine, as in law, the influence of precedent and well-established authority often obstructs the way of truth; and, when they are finally set aside, yields only to the pressure of accumulated facts. It requires a firmer array of facts to stem the current of opinion, which is the outcome of authority, than to establish a natural law. This is about the relation that intra-uterine mechanical support bears to standard authority in gynecic surgery. This force of authority is rendered still stronger in this relation by the fact that the history of intra-uterine stem-treatment is one of repeated failures up to the year 1870; and many of the recent works upon diseases of women speak either doubtfully of it, or condemn it in unmeasured terms. Importance, therefore, attaches to all additional experience that tends to prove the value of the intra-uterine stem in practice. This becomes all the more important in view of the difficulties which surround the treatment of the various degrees of anteflexion and -version. I speak for myself only when I say that

all the instruments, other than the intra-uterine stem, devised for the correction of these errors of position, have failed to amend the fault ; and, judging from the number of cases that have come into my hands from other physicians—some of them experts—I have not been solitary in my failures.

The causes of these failures are purely mechanical. There are no means, aside from intra-uterine support, that act so directly in restoring the displaced organ. The cause of this indirect action is the anterior vaginal wall intervening between the means of support and the part to be supported ; a vaginal wall, moreover, that participates in the displacement, and is a part of the error. It is this changed relation of the vagina, and the want of a fixed point of support anteriorly, which render the forward displacements so much more difficult to deal with than the backward ; the inner surface of the pubes is available as a point of intra-vaginal support in the latter, while in the former this point is directly under the part to be sustained, without any point of counter force. These are the main difficulties in the way of simply intra-vaginal mechanical treatment.

I shall refer briefly to those instruments which exert their sustaining force from a point external to the vagina. In order to illustrate this order of mechanical support, I shall select one, the type of all others not intra-uterine, and ideally the most perfect—Cutter's anteversion pessary, with Dr. Thomas's modification. In order to understand what this pessary really does when properly adjusted, let us examine the position of the anterior vaginal wall as implicated in the displacement. Anteriorly and below, the vagina has an unyielding point of origin in its osseous attachments ; above, it is subject to the varying positions of the uterus. In forward displacements, particularly of extreme degree, the anterior vaginal wall passes obliquely upward and backward across the vaginal vault to its insertion in the cervix, stretching it more and more as the cervix is forced backward and upward ; so that, in the extreme limit of malposition, the finger may detect the tension of the vagina and the nearly obliterated condition of the anterior transverse plicæ. Whatever the amount of deviation of the organ, the difference in effect upon the vaginal column is

simply that of degree in tension. Now, the transverse bar of the pessary, impinging upon this tense anterior wall of the vagina, is supposed to lift the fundus of the uterus; but it can only do so as it indents and uplifts the vaginal wall. This indentation cannot occur except by drawing the cervix toward the pubes. It is evident that all force which draws the cervix forward, without lifting the fundus to a corresponding degree, converts a version into a flexion, and, where the latter already exists, simply aggravates the deformity. The effect of the instrument upon the cervix is always in excess of its effect upon the depressed fundus. The operation of this pessary is complicated by another condition. By the altered position of the anterior vaginal wall, the lifting force of the instrument is deflected backward behind the point of available lifting force under the fundus. Its force is therefore expended, not under the depressed summit of the organ, but at the junction of the uterine body with the uterine neck. Any one can satisfy himself of the truth of this by examining the position of the transverse bar of the pessary after it has been worn for a few hours. What is really accomplished by the instrument is this: The cervix is drawn forward, and the entire uterus lifted in the pelvic space. It often relieves symptoms, not by the correction of the deformity, but by lifting the organ entire, its relative position of displacement remaining unchanged.

Hewitt's anteflexion pessary in extreme cases cannot be worn. The tense vaginal roof forces the anterior portion of the instrument downward from its point of support upon the pubes, and tends to partially expel the lower part of the instrument.

The intra-uterine stem with extra-vaginal support I shall not consider. Gynecic surgery has passed beyond such crude ideas. Notwithstanding the great name of Simpson and the ingenuity of Valleix, these instruments have been driven out of use by the general good sense of the profession. They violate every law of normal uterine movement, the complicated and important character of which I have already demonstrated.¹

¹ "A Study of the Normal Movements of the Unimpregnated Uterus," this JOURNAL for April, 1875.

It is, in brief, a method of impalement reduced to its possible minimum of danger to life.

In this criticism of some very popular instrumental appliances for the correction of anteflexion or version of the uterus, I speak from my own experience only, by which I feel myself justified in saying that I believe that the only road to certainty in the treatment of these deformities lies in the direction of greater perfection in intra-uterine stem-instruments with adjustable intra-vaginal support. But I do not wish the reader to draw the possibly too natural inference that the instruments figured in this paper avoid all the objections raised against the instruments named; but rather to show that we have many reasons to seek for improvements in the mechanical treatment of these deformities, and that we are yet far from the goal of a perfect pessary.

An instrument designed to correct the forward displacements must undergo a peculiar modification. This requires a vaginal attachment, so constructed as to bring the posterior vaginal wall into play as the point of counter-pressure to the force of anterior displacement.

An instrument of this character has been devised by Dr. Eklund, of Stockholm.¹ The reader can gain a good idea of this stem by imagining the flange, Fig. 3, to be rigidly fixed to the stem, Fig. 1. It is a broad expansion of the stem, its surface parallel with the axis of the stem. This pessary is used in either ante- or retroflexion or version, and the vaginal expansion is not designed to bring the posterior wall into action as a point of pressure, but to offer a broad surface to a tamping of cotton, which is placed in front of the flange in posterior displacements, thus crowding it backward against the posterior wall of the passage, and lifting the fundus accordingly; or, in the opposite form of dislocation, the cotton is placed posterior to the flange, thus pushing it forward against the bladder. So long as the cotton tamping is in place, of course the instrument answers its purpose; but those of us who have tried it know how difficult it is to keep a mass of cotton in one position in the vagina, especially any mass designed to be kept in the anterior *cul-de-sac*. An instru-

¹ *Obstetrical Journal of Great Britain and Ireland*, vol. ii., p. 561.

ment of this kind, with cotton tamping, is unnecessary in the treatment of retroflexions or versions. Accepting Dr. Eklund's pessary as the basis, I designed the flange figured in cut 3, and which expresses its average size. Its introduction is an easy matter. This stem, Fig. 1, is first placed in position, and the flange is then pushed up upon the wire until it rests against the shoulder *a* of the stem; the same manipulation as in the introduction of my retroflexion stem-pessary, now some time before the public.¹

This pessary is intended for the correction of forward displacements, and its principle of action is very simple. The portion *b* of the flange, a smooth and rounded surface, is pressed backward by the tendency of the uterus to anterior displacement against the posterior vaginal wall; the fundus is, therefore, maintained in an erect position. These instruments are made of hard rubber.

I can better illustrate the treatment of anteflexion of the uterus by the history of three cases:

CASE I.—Mrs. B., a spare brunette, aged thirty-one years; married; no children; two miscarriages, the last six years ago; occupied in the care of her house. The leading symptom in this case was ceaseless and tormenting vesical tenesmus, and which has been present nearly five years. She has been under the care of various physicians, and among them was a general practitioner with gynaecological proclivities, of considerable skill and experience, and who treated her locally, but without benefit. The last was an irregular German physician, who informed her that the urinary symptom was a sign of the last stage of syphilis. This information, with her bilious, gloomy temperament, produced a most unhappy mental condition, which, in connection with the domestic trouble that resulted, drove her nearly to the verge of insanity. During this period of mental excitement the vesical tenesmus was aggravated, often driving her from her bed two and three times an hour during the night. There was never at any time much leucorrhœa, and menstruation was normal, or but little deranged. Inspection showed the urinary meatus tumefied

¹ *Buffalo Medical and Surgical Journal*, April, 1874; and *Southern Medical Record*, November, 1874.

and inflamed, with slight eversion of the edges. On examination, the uterus was found in a complete state of anteflexion. It could be easily carried back into place by the sound; but on the withdrawal of the instrument quickly recoiled to its dislocated position. I at once expressed the opinion that the vesical irritation was due to the anteflexion; but, as the urethra had a suspicious appearance, I thought best to eliminate all other probable sources of the symptoms by a careful exploration of the urethra and bladder. With this in view, assisted by Dr. Frank H. Butler, of this city, who gave the anaesthetic, on the 24th of April, 1875, the urethra was rapidly dilated by the finger, so as to permit the index-finger to be swept round the neck of the bladder just beyond its urethral contraction, but without detecting any diseased condition. A small bivalve anal speculum was then introduced, and through its slightly-expanded blades a fair view could be had of the lining of the urethra, which appeared congested and thickened. Aside from this, nothing abnormal appeared. As this condition may have been the source of the vesical symptoms, I thought it better to treat it. By means of cotton wound upon a probe I applied chemically pure nitric acid to the entire extent of the urethra. The treatment, however, amounted to nothing, in a curative sense, but was well borne, and was unattended by incontinence of urine. Two weeks after the above date the



FIG. 1

stem represented in Fig. 1 was introduced, and secured in position by the flange, Fig. 3. The instrument was well

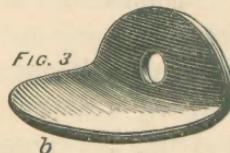


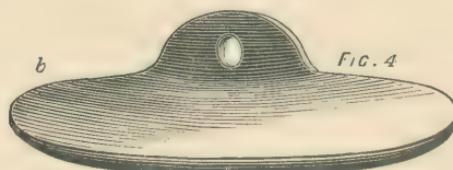
FIG. 3

borne, and the night following its introduction my patient was obliged to rise to void urine but twice, instead of as often every hour. The pessary was worn nearly constantly until

October, with complete relief of the symptoms. In that month Mrs. B. left Syracuse for Chicago, where, upon going to a physician to have the Stein replaced, she was surprised to learn of the fearful risk she had been exposed to by wearing such a dangerous instrument. As she could not have the pessary introduced, she concluded, if possible, to do without it. I saw Mrs. B. in January last, and she informed me that she was free from her vesical tenesmus, and had been so without interruption since October. She declined an examination, as she believed herself to be well.

CASE II.—Mrs. W., aged forty-three years; has been a widow two years; three children, the youngest six years old; occupation tailoress. In this case the morbid action of the uterine displacement seemed to expend its force upon the nervous system. There were an endless variety of subjective sensations, and a morbid craving for sympathy. Much of her time was passed upon a couch, or in bed. An examination proved that the uterus was in an extreme degree of anteverision. The os was forced backward and upward to such an extent that it was reached with difficulty by the finger. As usual, in version, it did not recoil so quickly to its faulty position after being replaced by the sound as in flexion. An effort was made to correct the version by means of the flange, Fig. 3; but it was found that, on account of the great capacity of the vagina and the strong tendency to version, the organ settled forward gradually, driving the flange upward and backward into the posterior vaginal *cul-de-sac*. An effort was made to correct this fault in the flange by making its flat vertical surface broader in the direction of *b*, Fig. 3. But this was found to bring its lower edge too near the ostium *vaginæ*, resting nearly upon the perineal body, so that it was being constantly expelled. Of course, while in place it kept the uterus in its correct position; nevertheless it was not practical. Being somewhat discouraged by my failure, it was some time before I made another attempt. The next effort was to devise a flange which would secure a larger posterior vaginal surface for it to rest against; a counterpoise, as it were, to the strong tendency to anteverision. There remained but one way in which this could be done; and that was, to enlarge the flange

laterally in the direction of *b*, Fig. 4. In order to render its introduction easy, a slot was cut upon opposite sides of the

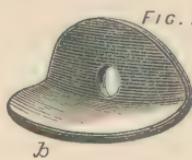


opening for the stem, which is not shown in the cut. These slots permitted the flange to be turned very obliquely upon the wire which carried the stem, so that it might be presented by its edge at the ostium vaginæ. Fig. 4 represents the actual size, and by means of the slots it was not more difficult of insertion than the flange, Fig. 3; and, as may be seen by a comparison with that cut, in its transverse diameter it is no larger. Taking into consideration the great capacity of the vagina, and the extreme degree and force of the version, the instrument worked remarkably well. It very seldom was expelled or got out of adjustment. Mrs. W. gradually improved in general health, spent less and less of her time in bed, and showed more of her former spirit of industry, although her mental tone revealed the severe shock to which it had been exposed. It now appears, at this writing (April 10th), that, while the prospect of a "cure" for Mrs. W. is very remote, she is still wearing her instrument with comfort most of the time, and is earning her living as a tailoress, which she had been unable to do for two years previous to the treatment.

CASE III.—Mrs. S., aged thirty-four years; has been married eighteen months; no children; previous to her marriage had taught school many years; since her marriage her occupation is that of a farmer's wife. In *physique* she is a tall, colorless blonde. Mrs. S. was brought to me by her family physician, Dr. S. M. Higgins of Memphis, N. Y. It is needless for the purpose for which her case is cited here to detail the symptoms; they were of such a nature as led her physician, an energetic and accomplished medical man, to arrive at their origin^z by an examination of the pelvic organs. On examining for myself I found a discouraging state of things.

The vaginal cavity was very much contracted, but normally so, the uterus low, the cervix slightly elongated and conical, the finger meeting it about an inch and a half from the ostium *vaginæ*, and the uterus was sharply anteflexed, the seat of the flexure being at the junction of the uterine body with the uterine neck. The flexed organ possessed great resilience. From its small size and the general condition of the parts, I was induced to believe that the flexion was either congenital, or dated from early menstrual life. It was an excellent case for division of the cervix anteriorly; but to any thing in the nature of a surgical operation the patient or her husband would not listen. The first difficulty that presented itself in the way of a mechanical correction of the deformity was the shortness of the vagina, which prevented elevation of the organ so as to admit the smallest flange in my possession. A flange the size of Fig. 3, when in position, presented its lower edge just within the labia, and caused so much pain that I at once removed it. It was evident that I would have to construct a vaginal attachment smaller than any I had ever yet devised; and at the same time with a surface sufficiently large to secure a due amount of counter-force by pressure against the posterior vaginal wall. From a wax model Dr. A. J. Dallas, Jr., a dentist, constructed out of hard rubber the flange represented in Fig. 2, and which is slightly larger

FIG. 2



b

than the original. This instrument was introduced without difficulty and was worn with comfort. Unfortunately I can only allude to this case as one in which many obstacles in the way of mechanically treating a severe form of anteflexion were overcome by a simple device, and as one eminently calculated to illustrate the purpose of this paper. Mrs. S. in February last, after a severe day's work about her house, was suddenly attacked by some form of cerebral disease, and, becoming rapidly unconscious, she died in about twenty-four

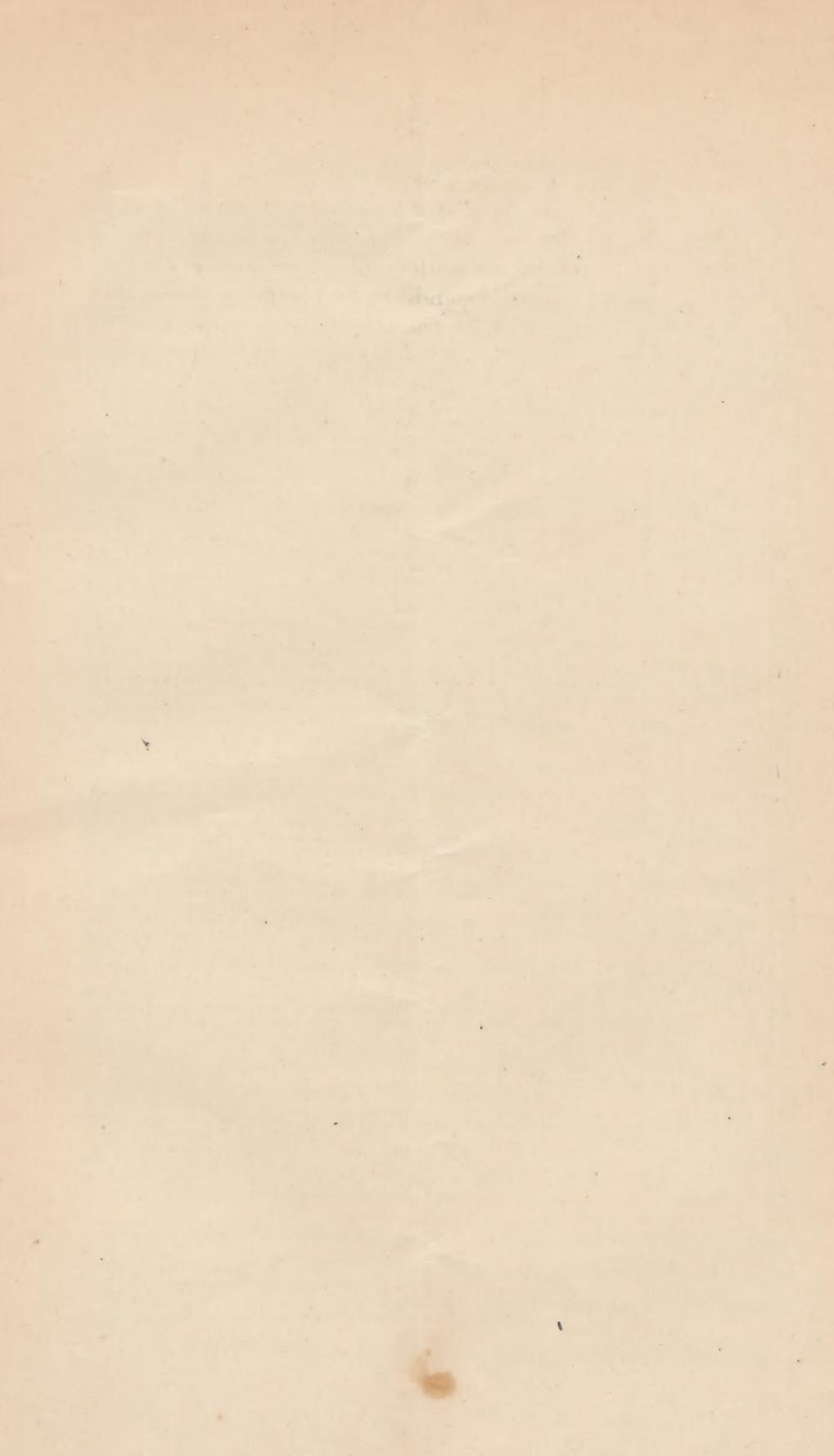
hours. No *post-mortem* examination was allowed. She had completed menstruation—still wearing the stem—about ten days previously to her fatal sickness, the function being performed with less general disturbance to the system than usual.

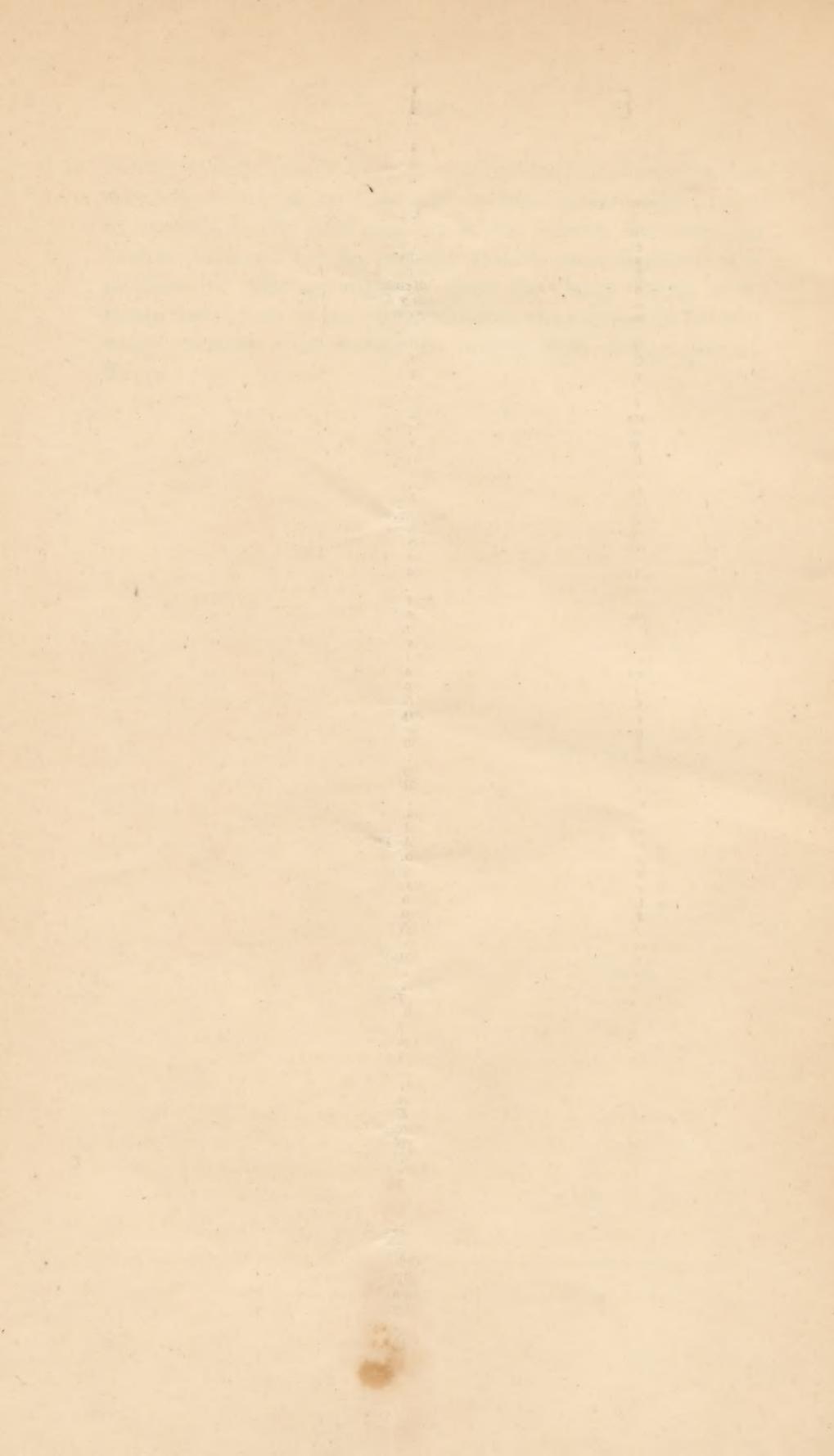
The point in the mechanical treatment of anteversions or flexion, or, in fact, the opposite form of uterine dislocations, which these cases are designed to illustrate, is that we cannot place our reliance upon any one form of instrument. The simple difference in size, which constitutes the variety in any one form of pessary, is not sufficient to meet the requirements of particular cases. It is safe to say that no two vaginae are alike, and the extent to which they differ in capacity is but a minor difference. If we were to fail in correcting a flexion with one size of pessary for sale by the makers, it would not follow that the size larger or smaller, as the case might be, should succeed where the other failed; but we ought rather to consider that the case may be one that demands some other form of mechanical correction. Contrast the two Cases II. and III., and the reader will perceive at once that a simple difference in size in the form of flange I usually employed (Fig. 3), would not enable a physician to treat either of these cases. In order to apply the same principle to the treatment of the three cases, it was necessary to essentially modify it in the management of the last two. Now, the usual method is too mechanical. A physician, if he relies upon the instrument-makers, has only a choice of a difference in size in any one instrument he may select. The more complicated the instrument the greater the reason, oftentimes, for changes in form other than that of size. In using Dr. Thomas's anteverision pessary, as sold by the makers, I have several times been obliged to shorten the bow; this may not be the fault of the idea of the instrument, but rather of the maker, for my own brief experience teaches me that a pessary is one thing after it comes from the hands of the inventor, and another thing coming from the hands of the maker. The gynaecologist is not altogether blameless in the matter. If he possesses any ingenuity at all, he invents an instrument, usually a pessary; and, because it succeeds well in one case, he places it at once in the hands of an instrument-maker, who advertises it accord-

ngly as an instrument designed to correct a certain form of uterine dislocation, and both the inventor and the maker seem to believe that by producing two or three sizes they are providing for every probable variation of condition in any case. We have a class of gynæcologists, both in this country and in England, who seem to devote a large amount of their time to mechanical inventions, if we are entitled to judge by the fact that they rarely come before the professional public except in connection with some new gynecic device. I cannot avoid the belief that this multiplicity of instruments is working harm, rather than good, to the cause of special medicine or surgery, as it is constantly leading to disappointment on the part of the general practitioner, who is obliged oftentimes to rely upon himself, and thus causing a distrust of those who profess special training in one department. It may be objected that the surgeon cannot be constantly inventing modifications or new appliances for his clients; but, if he is to treat cases of this nature successfully, he must be an inventor, not once, but all the time. Nor is it so much a matter of pure invention as may be supposed. It is the case before one, and not one's originality, that suggests the new instrument or the modification of the old one. The surgeon has but to receive the hint and act upon it.

A very convenient way for physicians who cannot take their orders personally to the special manufacturer of these instruments is, to establish relations with some dentist who makes rubber dental plates, and is therefore able to make small vulcanite instruments, such as are figured in this article. From a careful study of his case, the physician may prepare a model in wax which the dentist can easily copy in hard rubber. In this way changes in form and size may be made until the particular case under observation is fitted with its proper form of instrument. This method of procuring ante- or retroflexion instruments may be more costly than ordering through the regular channels of the trade, but the certainty of perfectly adapting the mechanical treatment to the particular requirements of the case counterbalances the increased expense. In the slighter forms of version, the block-tin rings or copper-wire rings covered with pure gum, which may be procured in a great

variety of sizes, can be bent or moulded into any form the case may require. I am satisfied that the stem-pessary ought to be made specially for each case. I do not believe that they can be manufactured for the trade in three or more sizes and give satisfaction. Success depends upon the flange being accurately fitted, and, if the physician does not succeed in his first model, further trial is sure to reward him with a perfect flange.





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